NEW YORK PARTNERSHIP PLAN
SECTION 1115 DEMONSTRATION FACT SHEET

Revised October 1, 2006

Name of Section 1115 Demonstration:	The Partnership Plan
Waiver Number:	11-W-00114/2
Date Proposal Submitted:	March 20, 1995
Date 1115(a) Demonstration Approved:	July 15, 1997
Date 1115(a) Demonstration Effective:	October 1, 1997 (in phases)
Date 1115(a) Demonstration Expired:	March 31, 2003
Date 1115(e) Extension Submitted:	March 29, 2002
Date 1115(e) Extension Approved:	September 27, 2002
Date 1115(e) Extension Effective:	April 1, 2003
Date 1115(e) Extension Expired:	March 31, 2006
Date 1115(f) Extension Submitted:	November 23, 2005
Date 1115(f) Extension Approved:	September 29, 2006*****
Date 1115(f) Extension Effective:	October 1, 2006
Date 1115(f) Extension Expires:	September 30, 2009

⋆ The demonstration was extended ten times for a total of six months between March 31, 2006 and October 1, 2006.

SUMMARY

The State's goal in implementing the Demonstration is to improve the health status of low-income New Yorkers by:

- improving access to health care for the Medicaid population;
- improving the quality of health services delivered; and
- expanding coverage to additional low income New Yorkers with resources generated through managed care efficiencies.

The Partnership Plan section 1115 demonstration uses a managed care delivery system to create efficiencies in the Medicaid program and enable the extension of coverage to certain individuals who would otherwise be without health insurance. The initial Partnership Plan demonstration was approved in 1997 to enroll most Medicaid beneficiaries into managed care organizations (Medicaid managed care program). In 2001, the Family Health Plus program was implemented as an amendment to the demonstration, providing comprehensive health coverage to low-income uninsured adults, with and without children, who have income and/or assets greater than Medicaid eligibility standards. In 2002, the demonstration was further amended to provide family planning services to women losing Medicaid eligibility and certain other adults of childbearing age (family planning expansion program).

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As of September, 2006, the Partnership Plan Demonstration has approximately 2.57 million beneficiaries: 2 million in the Medicaid managed care program; 510,000 in the Family Health Plus program; and 66,000 in the family planning expansion program.

AMENDMENTS

Amendment #1:	The Family Health Plus program expands health insurance coverage to uninsured adults, whose income and/or assets exceed Medicaid eligibility requirements.
Date Amendment #1 Submitted:	June 30, 2000
Date Amendment #1 Approved:	June 29, 2001
Date Amendment #1 Effective:	October 1, 2001
Amendment #2:	The family planning expansion program provides family planning services only to Medicaid-eligible women who have lost pregnancy coverage under the Partnership Plan at the conclusion of their 60-day postpartum period, as well as certain men and women of childbearing age.
Date Amendment #2 Submitted:	January 16, 2001
Date Amendment #2 Approved:	September 27, 2002
Date Amendment #2 Approved:	October 1, 2002
Amendment #3:	Dual eligible beneficiaries in the Partnership Plan are permitted to enroll on a voluntary basis into one managed care plan for both Medicare and Medicaid services (a Medicaid MCO and a Medicare Advantage Plan).
Date Amendment #3 Submitted:	April 20, 2004
Date Amendment #3 Approved:	December 15, 2004
Date Amendment #3 Effective:	January 1, 2005

ELIGIBILITY AND ENROLLMENT

Medicaid managed care program *:	All TANF and TANF-related Medicaid State Plan-eligible individuals in most New York counties, as well as Safety Net (formerly Home Relief) recipients are included.
Family Health Plus:	Childless adults with gross incomes at or below 100 percent of the FPL and resources not exceeding 150 percent of the medically needy Medicaid income standard; Adults with children with gross incomes at or below 150 percent of the FPL and resources not exceeding 150 percent of the medically needy Medicaid income standard.
Family Planning Expansion:	Women who have lost pregnancy coverage under the Partnership Plan at the conclusion of their 60-day

postpartum period as well as men and women of childbearing age with net incomes at or below 200 percent of the FPL who are not otherwise eligible for Medicaid or other public or private health insurance coverage that provides family planning services.

* Effective October 1, 2006, the authority to require disabled adults and children, as well as the elderly, to enroll in the Medicaid managed care program has been transferred from this demonstration to the Federal-State Health Reform Partnership (F-SHRP) Demonstration (11-W-00234/2). This includes individuals dually eligible for Medicare and Medicaid who are included in the F-SHRP demonstration but may enroll on a voluntary basis.

Certain categories of individuals are excluded from the demonstration. These include:

- individuals in permanent residency in a residential health care facility;
- individuals receiving hospice care prior to managed care enrollment;
- individuals who are served through a Home and Community-Based Services waiver program;
- individuals who spend down and become eligible for the Medically Needy program;
- infants of incarcerated women;
- individuals expected to be eligible less than six months (e.g., seasonal agricultural workers); and
- individuals with access to cost-effective private health insurance.

Enrollment for some groups is voluntary. In general, homeless individuals and most children in foster care are exempt from the demonstration with some allowance provided for county-by-county policy variations.

New York has received Federal approval to continue its facilitated enrollment program. Under this program, health plans, community-based organizations and providers are permitted to:

- Conduct the face-to-face interview of potential beneficiaries required by New York State law;
- Review documentation needed for eligibility determination for SCHIP, Medicaid and Family Health Plus;
- Assist the beneficiary in selecting a managed care organization; and
- Assist beneficiaries in maintaining eligibility by facilitating recertification for benefits.

Language in the Special Terms and Conditions governing the demonstration requires the State to closely monitor choice counseling activities to minimize adverse risk selection, and specifies that determinations of Medicaid eligibility are made solely by the local Departments of Social Services.

DELIVERY SYSTEM

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The State directly contracts with commercial MCOs and State-certified Prepaid Health Services Plans (PHSPs) for the Partnership Plan. Capitated Special Needs Plans (SNPs) have been developed to serve individuals with HIV/AIDS who require intensive case-managed care regimens, and their families. All beneficiaries in the demonstration must use providers within their managed care plan. The State has contracted with a commercial insurer to provide services to Family Health Plus recipients who are in the eleven counties that do not have managed care plans participating in Family Health Plus.

BENEFITS

Managed care beneficiaries in the Partnership Plan, excluding those enrolled in Family Health Plus, receive to the same comprehensive benefits package available under the fee-for-service program. Certain services, such as long-term care services, continue to be provided on a fee-for-service basis. Other services, such as transportation and dental care, may be provided on a fee-for-service basis or as part of the capitated managed care service package at county discretion. Family planning services can be obtained from any provider offering such services to Medicaid beneficiaries.

The State also offers certain services on a fee-for-service wraparound basis to individuals who exceed a basic benefit threshold within their managed care plans. For example, individuals who exhaust their basic benefits as defined in the capitation rates are able to receive mental health inpatient and outpatient services, and medically necessary chemical dependency treatment services on a fee-for-service basis.

Family Health Plus benefits are less comprehensive than those offered by Medicaid, and does not provide carve-outs or fee-for-service wrap around services. Family Health Plus does not cover long-term care services for the chronically ill, non-emergency transportation, medical supplies or non-prescription drugs, except for smoking cessation products. Limitations apply to home health services and inpatient psychiatric care. Dental services are available to the extent that the beneficiary's plan offers such services. Finally, cost-sharing is imposed as described below.

QUALITY AND EVALUATION PLAN

Under the demonstration, the State and contracting health plans are required to develop comprehensive quality assurance monitoring programs, including beneficiary satisfaction surveys and focused studies on significant health issues.

Quality monitoring consists of the following tools: Medicaid encounter data; Quality Assurance Reporting Requirements (QARR); member satisfaction surveys; and External Quality Reviews by IPRO.

In its eight years of operations, some of the quality outcomes of the Partnership Plan include an increase in the number of primary care providers serving Medicaid beneficiaries, as well as better access to specialists than fee-for-service beneficiaries. Partnership Plan health plans outscore national Medicaid benchmarks on a number of quality indicators, including lead testing for children and management of adult asthma. Finally, four of the top ten Medicaid health plans

in the country are serving New York Partnership Plan beneficiaries, as ranked by US News and World Report.

A comprehensive evaluation of the demonstration will be completed no later than March 31, 2009. This will include separate evaluations of the Partnership Plan as well as the Family Planning Expansion program.

COST SHARING

Medicaid beneficiaries are exempt from cost-sharing. However, Family Health Plus beneficiaries are charged the following co-payments.

- Pharmacy:
  - $6 for brand name prescriptions
  - $3 for generic prescriptions
- Clinic - $5 per visit
- Physician - $5 per visit
- Dental - $5 per visit with a $25 maximum annual cap
- Lab Tests - $.50
- Radiology (ordered ambulatory) - $1
- Inpatient Hospital - $25 per stay
- Non-Emergent Emergency Room - $3

STATE FUNDING SOURCE

The demonstration is funded with Title XIX funds.

Contact: Camille Dobson (410) 786-7062
Camille.Dobson@cms.hhs.gov

Ricardo Holligan (212) 616-2424
Ricardo.Holligan@cms.hhs.gov

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